KENTUCKY MEDICAL ASSISTANCE PROGRAM

HOSPICE PROGRAM MANUAL

POLICIES AND PROCEDURES

Cabinet for Human Resources
Department for Medicaid Services
Frankfort, Kentucky 40621

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SECTION I - INTRODUCTION

I. INTRODUCTION

This new edition of the Kentucky Medical Assistance Program Hospice Program Manual has been formulated with the intention of providing you, the provider with a useful tool for interpreting the procedures and policies of the Kentucky Medical Assistance Program. It has been designed to facilitate the processing of your claims for services provided to qualified recipients of Medicaid.

This manual is intended to provide basic information concerning coverage, billing, and policy. It will, hopefully, assist you in understanding what procedures are reimbursable, and will also enable you to have your claims processed with a minimum of time involved in processing rejections and making inquiries. It has been arranged in a loose-leaf format, with a decimal page numbering system which will allow policy and procedural changes to be transmitted to you in a form which may be immediately incorporated into the manual (i.e., page 7.6 might be replaced by new pages 7.6 and 7.7).

Precise adherence to policy is imperative. In order that your claims may be processed quickly and efficiently, it is extremely important that you follow the policies as described in this manual. Any questions concerning general agency policy should be directed to the Office of the Commissioner, Department for Medicaid Services, Cabinet for Human Resources, CHR Building, Frankfort, Kentucky 40621, or Phone (502) 564-4321. Questions concerning the application or interpretation of agency policy with regard to individual services should be directed to the Division of Policy and Provider Services, Department for Medicaid Services, Cabinet for Human Resources, CHR Building, Frankfort, Kentucky 40621, or Phone (502) 564-6890. Questions concerning billing procedures or the specific status of claims should be directed to EDS, P.O. Box 2009, Frankfort, KY 40602, or Phone (800) 333-2188 or (502) 227-2525.

SECTION I - INTRODUCTION

B. Fiscal Agent

Effective December 1, 1983, Electronic Data Systems (EDS) will provide fiscal agent services for the operation of the Kentucky Medicaid Management Information System (MMIS). EDS will receive and process all claims for medical services provided to Kentucky Medicaid recipients.

SECTION II - KENTUCKY MEDICAL ASSISTANCE PROGRAM (KMAP)

II. KENTUCKY MEDICAL ASSISTANCE PROGRAM (KMAP)

A. General

The Kentucky Medical Assistance Program, frequently referred to as the Medicaid Program, is administered by the Cabinet for Human Resources, Department for Medicaid Services. The Medicaid Program, identified as Title XIX of the Social Security Act, was enacted in 1965, and operates according to a State Plan approved by the U. S. Department of Health and Human Services.

Title XIX is a joint Federal and State assistance program which provides payment for certain medical services rendered to Kentucky recipients who lack sufficient income or other resources to meet the cost of such care. The basic objective of the Kentucky Medical Assistance Program is to aid the medically indigent of Kentucky in obtaining quality medical care.

As a provider of medical services, you must be aware that the Department for Medicaid Services is bound by both Federal and State statutes and regulations governing the administration of the State Plan. The Department cannot reimburse you for any services not covered by the plan. The state cannot be reimbursed by the federal government for monies improperly paid to providers of non-covered unallowable medical services.

The Kentucky Medical Assistance Program, Title XIX, Medicaid, is not to be confused with Medicare. Medicare is a Federal program, identified as Title XVIII, basically serving persons 65 years of age and older, and some disabled persons under that age.

The Kentucky Medicaid Program serves eligible recipients of all ages. The coverage, either by Medicare or Medicaid, will be specified in the body of this manual in Section IV.

SECTION II - KENTUCKY MEDICAL ASSISTANCE PROGRAM (KMAP)

B. Administrative Structure

The Department for Medicaid Services within the Cabinet for Human Resources, bears the responsibility for developing, maintaining, and administering the policies and procedures, scopes of benefits, and basis for reimbursement for the medical care aspects of the Program. The Department for Medicaid Services makes the actual payments to the providers of medical services, who have submitted claims for services within the scope of covered benefits which have been rendered to eligible recipients.

Determination of the eligibility status of individuals and families for Medical Assistance benefits is a responsibility of the local Department for Social Insurance Offices, located in each county of the state.

C. Advisory Council

The Kentucky Medical Assistance Program is guided in policy-making decisions by the Advisory Council for Medical Assistance. In accordance with the conditions set forth in KRS 205.540, the Council is composed of fifteen members, including the Secretary of the Cabinet for Human Resources, who serves as an ex officio member. The remaining fourteen members are appointed by the Governor to four-year terms. Nine members represent the various professional groups providing services to Program recipients, and are appointed from a list of three nominees submitted by the applicable professional associations. The other five members are lay citizens.

In accordance with the statutes, the Advisory Council meets at least every three months and as often as deemed necessary to accomplish their objectives.

In addition to the Advisory Council, the statutes make provision for a five-member technical advisory committee for certain provider groups. Membership on the technical advisory committees is decided by the professional organization that the technical advisory committee represents. The technical advisory committees provide for a broad professional representation to the Advisory Council.

As necessary, the Advisory Council appoints subcommittees or ad hoc committees responsible for studying specific issues and reporting their findings and recommendations to the Council.

D. Policy

The basic objective of the Kentucky Medical Assistance Program hereinafter referred to as KMAP, is to assure the availability and accessibility of quality medical care to eligible Program recipients.

The 1967 amendments to the Social Security Law stipulates that Title XIX Programs have secondary liability for medical costs of Program recipients. That is, if the patient has an insurance policy, veteran's coverage, or other third party coverage of medical expenses, that party is primarily liable for the patient's medical expenses. The Medical Assistance Program has secondary liability. Accordingly, the provider of service should seek reimbursement from such third party groups for medical services rendered. If you, as the provider, should receive payment from the KMAP before knowing of the third party's liability, a refund of that payment amount should be made to the KMAP, as the amount payable by the Cabinet shall be reduced by the amount of the third party obligation.

In addition to statutory and regulatory provisions, several specific policies have been established through the assistance of professional advisory committees. Principally, some of these policies are as follows:

All participating providers must agree to provide services in compliance with federal and state statutes regardless of sex, race, creed, religion, national origin, handicap, or age.

SECTION II - KENTUCKY MEDICAL ASSISTANCE PROGRAM (KMAP)

Each medical professional is given the choice of whether or not to participate in the Kentucky Medical Assistance Program. From those professionals who have chosen to participate, the recipient may choose the one from whom he wishes to receive his or her medical care.

When the Cabinet makes payment for a covered service and the provider accepts the payment made by the Cabinet in accordance with the Cabinet's fee structure, the amounts paid shall be considered payment in full; and no bill for the same service shall be tendered to the recipient, or payment for the same service accepted from the recipient.

Providers of medical service attest by their signatures (not facsimiles) that the presented claims are valid and in good faith. Fraudulent claims are punishable by fine and/or imprisonment. Stamped signatures are not acceptable.

All claims and substantiating records are auditable by both the Government of the United States and the Commonwealth of Kentucky.

All claims and payments are subject to rules and regulations issued from time to time by appropriate levels of federal and state legislative, judiciary and administrative branches.

All services to recipients of this Program shall be on a level of care at least equal to that extended private patients, and normally expected of a person serving the public in a professional capacity.

All recipients of this Program are entitled to the same level of confidentiality accorded patients <u>not</u> eligible for Medicaid benefits.

Professional services shall be periodically reviewed by peer groups within a given medical specialty.

All services are reviewed for recipient and provider abuse. Willful abuse by the provider may result in his or her suspension from Program participation. Abuse by the recipient may result in surveillance of the payable services he or she receives.

No claim may be paid for services outside the scope of allowable benefits within a particular specialty. Likewise, no claims will be paid for services that required, but did not have, prior authorization by the Kentucky Medical Assistance Program.

No claims may be paid for medically unnecessary items, services, or supplies.

When a recipient makes payment for a covered service, and such payment is accepted by the provider as either partial payment or payment in full for that service, no responsibility for reimbursement shall attach to the Cabinet and no bill for the same service shall be paid by the Cabinet.

E. Public Law 92-603 (As Amended)

Section 1909. (a) Whoever--
(1) knowingly and willfully makes or causes to be made any false statement or representation of a material fact in any application for any benefit or payment under a State plan approved under this title,
(2) at any time knowingly and willfully makes or causes to be made any false statement or representation of a material fact for use in determining rights to such benefit or payment,
(3) having knowledge of the occurrence of any event affecting (A) his initial or continued right to any such benefit or payment, or (B) the initial or continued right to any such benefit or payment of any other individual in whose behalf he has applied for or is receiving such benefit or payment, conceals or fails to disclose such event with an intent fraudulently to secure such benefit or payment either in a greater amount or quantity than is due or when no such benefit or payment is authorized, or

(4) having made application to receive any such benefit or payment for the use and benefit of another and having received it, knowingly and willfully converts such benefit or payment or any part thereof to a use other than for the use and benefit of such other person,

shall (i) in the case of such a statement, representation, concealment, failure, or conversion by any person in connection with the furnishing (by that person) of items or services for which payment is or may be made under this title, be guilty of a felony and upon conviction thereof fined not more than $25,000 or imprisoned for not more than five years or both, or (ii) in the case of such a statement, representation, concealment, failure, or conversion by any other person, be guilty of a misdemeanor and upon conviction thereof fined not more than $10,000 or imprisoned for not more than one year, or both. In addition, in any case where an individual who is otherwise eligible for assistance under a State plan approved under this title is convicted of an offense under the preceding provisions of this subsection, the State may at its option (notwithstanding any other provision of this title or of such plan) limit, restrict, or suspend the eligibility of that individual for such period (not exceeding one year) as it deems appropriate; but the imposition of a limitation, restriction, or suspension with respect to the eligibility of any individual under this sentence shall not affect the eligibility of any other person for assistance under the plan, regardless of the relationship between that individual and such other person.

(b)(1) Whoever knowingly and willfully solicits or receives any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind--,

(A) in return for referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under this title, or

(B) in return for purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under this title,

shall be guilty of a felony and upon conviction thereof, shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

(2) Whoever knowingly and willfully offers or pays any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind to any person to induce such person--

(A) to refer an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under this title, or

(B) to purchase, lease, order, or arrange for or recommend purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under this title,

shall be guilty of a felony and upon conviction thereof shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

(3) Paragraphs (1) and (2) shall not apply to--

(A) a discount or other reduction in price obtained by a provider of services or other entity under this title if the reduction in price is properly disclosed and appropriately reflected in the costs claimed or charges made by the provider or entity under this title; and

(B) any amount paid by an employer to an employee (who has a bona fide employment relationship with such employer) for employment in the provision of covered items or services.

(c) Whoever knowingly and willfully makes or causes to be made, or induces or seeks to induce the making of, any false statement or representation of a material fact with respect to the conditions or operation of any institution or facility in order that such institution or facility may qualify (either upon initial certification or upon recertification) as a hospital, skilled nursing facility, intermediate care facility, or home health agency (as those terms are employed in this title) shall be guilty of a felony and upon conviction thereof shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

(d) Whoever knowingly and willfully--
(1) charges, for any service provided to a patient under a State plan approved under this title, money or other consideration at a rate in excess of the rates established by the State, or
(2) charges, solicits, accepts, or receives, in addition to any amount otherwise required to be paid under a State plan approved under this title, any gift, money, donation, or other consideration (other than a charitable, religious, or philanthropic contribution from an organization or from a person unrelated to the patient)--
(A) as a precondition of admitting a patient to a hospital, skilled nursing facility, or intermediate care facility, or
(B) as a requirement for the patient's continued stay in such a facility,
when the cost of the services provided therein to the patient is paid for (in whole or in part) under the State plan,
shall be guilty of a felony and upon conviction thereof shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

F. Timely Submission of Claims

In order to receive Federal Financial Participation, claims for covered services rendered eligible Title XIX recipients must be received by the Department for Medicaid Services within twelve (12) months from the date of service. Claims received after that date will not be payable. This policy became effective August 23, 1979.

G. Kentucky Patient Access and Care System (KenPAC)

KenPAC is a statewide patient care system which, as an adjunct to the Kentucky Medical Assistance Program (KMAP), provides certain categories of medical recipients with a primary physician or family doctor. Only those Medicaid recipients who receive medical assistance under the Aid to Families with Dependent Children (AFDC), or AFDC-related categories are covered by KenPAC. Specifically excluded are: the aged, blind, and disabled categories of recipients; skilled nursing facility (SNF), intermediate care facility (ICF), and personal care (PC) residents; mental hospital patients; foster care cases; refugee cases; all spend-down cases; and all Lock-In cases. To aid in distinguishing from regular KMAP recipients, the KenPAC recipients will have a color-coded KMAP card with the name, address, and telephone number of their primary care provider.

The primary care physician is listed on the green KenPAC medical card. The Hospice Program is not currently affected by KenPAC.

SECTION III - DEVELOPMENT OF HOSPICE SERVICES

III. DEVELOPMENT OF HOSPICE SERVICES

Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272)

On April 7, 1986, the President signed into law H.R. 3128, The Consolidated Omnibus Budget Reconciliation Act of 1985, (COBRA). The provisions of Section 9505 of this act allowed states to include under their State Plan for Medical Assistance, hospice benefits for terminally ill recipients who elect to receive it.

The law specifies that states must require participating providers of Hospice services to meet the same requirements for organization and operation as are required under Medicare. Reimbursement for covered services must also follow Medicare's reimbursement methodology.

The Commonwealth of Kentucky, Cabinet for Human Resources, Department for Medicaid Services, will implement the hospice benefit, effective 10/01/86.

SECTION IV - CONDITIONS OF PARTICIPATION

IV. CONDITIONS OF PARTICIPATION

A. Provider Participation Requirements

In order to be eligible to participate in the Kentucky Medical Assistance Program as a provider of Hospice services, the Hospice must first be licensed by the Kentucky Health Facilities and Health Services Certificate of Need and Licensure Board to provide hospice services in accordance with the requirements set forth in 902 KAR 20:140, and be certified by Title XVIII, Medicare, as a provider of hospice services. Further, the hospice must meet any additional certification requirements of the Title XIX program as outlined in 907 KAR 1:330 in the provision of covered hospice services required to meet the needs of the client. These services may be provided directly or through written contractual arrangements with another individual or entity for which the participating provider will be held responsible.

B. Application for Participation

An application for participation in the Title XIX Hospice Program element shall consist of the following:

1) Participation Agreement (MAP-343)
2) Provider Information Form (MAP-344)
3) Copy of Medicare form listing Medicare payment rates
4) Copy of Medicare Certification Letter
5) Copy of Certificate of Need

Copies of the Participation Agreement and Provider Information Form may be found in Appendix III and IV of this manual.

The completed Application for Participation should be sent to the following address:

Cabinet for Human Resources
Department for Medicaid Services
Provider Enrollment
275 East Main Street
Frankfort, KY 40621

Approval of an Application for Participation will include a signed copy of the Agreement and notification of the billing provider number.

SECTION IV - CONDITIONS OF PARTICIPATION

C. Change in Service Area

If there is a change in the provider's service area (adding or deleting a county or counties to be served) a copy of the new Certificate of Need identifying that change must be sent to the Department for Medicaid Services as soon as it is received by the provider so that the local Department for Social Insurance Offices can be notified that the provider is now available or unavailable in that county.

D. Licensure

Employees who provide hospice services must be licensed, certified or registered in accordance with applicable Federal or state laws.

E. Medical Director

The medical director must be a hospice employee who is a doctor of medicine or osteopathy who assumes overall responsibility for the medical component of the hospice's patient care program.

F. Continuation of Care

A hospice may not discontinue or diminish care provided to a Medicaid beneficiary because of the beneficiary's inability to pay for that care.

G. Informed Consent

A hospice must demonstrate respect for an individual's rights by ensuring that an informed consent form that specifies the type of care and services that may be provided as hospice care during the course of the illness has been obtained for every individual, either from the individual or the individual's representative.

SECTION IV - CONDITIONS OF PARTICIPATION

H. Interdisciplinary Group

1. The hospice must designate an interdisciplinary group or groups composed of the following individuals who are employees of the Hospice and who provide or supervise the care and services offered by the hospice.

   a. a doctor of medicine or osteopathy
   b. a registered nurse
   c. a social worker
   d. a pastoral or other counselor

2. The interdisciplinary group is responsible for the following:

   a. participation in the establishment of the plan of care

   b. provision or supervision of hospice care and services

   c. periodic review and updating of the plan of care for each individual receiving hospice care

   d. establishment of policies governing the day-to-day provision of hospice care and services.

3. If a hospice has more than one interdisciplinary group, it must designate in advance the group it chooses to execute the functions described above.

4. The hospice must designate a registered nurse to coordinate the implementation of the plan of care for each patient.

I. Plan of Care

A written plan of care must be established and maintained for each individual admitted to a hospice program, and the care provided to an individual must be in accordance with the plan.

1. The plan must be established by the attending physician, the medical director or physician designee and interdisciplinary group prior to providing care.

2. The plan must be reviewed and updated at intervals specified in the plan by the attending physician, the medical director, or physician designee and interdisciplinary group. These reviews must be documented.

3. The plan must include the assessment of the individual's needs and identification of the services including the management of discomfort and symptom relief. It must state in detail the scope and frequency of services needed to meet the patient's and family's needs.

J. Medical Records

1. Medical records must substantiate the services billed to the KMAP by the hospice. The medical records must be accurate and appropriate and must include the following:

   a. the initial and subsequent assessments
   b. the plan of care
   c. identification data
   d. consent and authorization and election forms
   e. pertinent medical history
   f. complete documentation of all services and events (including evaluations, treatments, progress notes, etc.)

2. All records must be signed by the staff person providing the service and dated.

3. Medical records must be maintained for a minimum of five years and for any additional time as may be necessary in the event of an audit exception or other dispute. The records and any other information regarding payments claimed must be maintained in an organized central file and furnished to employees of the Cabinet for Human Resources or Federal Government upon request, and made available for inspection and/or copying by Cabinet personnel.

SECTION IV - CONDITIONS OF PARTICIPATION

K. Termination of Participation

907 KAR 1:220 regulates the terms and conditions of provider participation and procedures for provider appeals. The Cabinet for Human Resources determines the terms and conditions for participation of vendors in the Kentucky Medical Assistance Program and may suspend, terminate, deny or not renew a vendor's provider agreement for "good cause." "Good cause" is defined as:

1. Misrepresenting or concealing facts in order to receive or to enable others to receive benefits;

2. Furnishing or ordering services under Medicaid that are substantially in excess of the recipient's needs or that fail to meet professionally recognized health care standards;

3. Misrepresenting factors concerning a facility's qualifications as a provider;

4. Failure to comply with the terms and conditions for vendor participation in the program and to effectively render service to recipients; or

5. Submitting false or questionable charges to the agency.

The Kentucky Medical Assistance Program shall notify a provider in writing at least fifteen (15) days prior to the effective date of any decision to terminate, suspend, deny or not renew a provider agreement. The notice will state:

1. The reasons for the decision;

2. The effective date;

3. The extent of its applicability to participation in the Medical Assistance Program;

4. The earliest date on which the Cabinet will accept a request for reinstatement;

5. The requirements and procedures for reinstatement; and

6. The appeal rights available to the excluded party.

The provider receiving such notice may request an evidentiary hearing. The request must be in writing and made within five (5) days of receipt of the notice.

The hearing shall be held within thirty (30) days of receipt of the written request, and a decision shall be rendered within thirty (30) days from the date all evidence and testimony is submitted. Technical rules of evidence shall not apply. The hearing shall be held before an impartial decision-maker appointed by the Secretary for Human Resources. When an evidentiary hearing is held, the provider is entitled to the following:

1. Timely written notice as to the basis of the adverse decision and disclosure of the evidence upon which the decision was based;

2. An opportunity to appear in person and introduce evidence to refute the basis of the adverse decision;

3. Counsel representing the provider;

4. An opportunity to be heard in person, to call witnesses, and to introduce documentary and other demonstrative evidence; and

5. An opportunity to cross-examine witnesses.

The written decision of the impartial hearing officer shall state the reasons for the decision and the evidence upon which the determination is based. The decision of the hearing officer is the final decision of the Cabinet for Human Resources.

These procedures apply to any individual provider who has received notice from the Cabinet of termination, suspension, denial or non-renewal of the provider agreement or of suspension from the Kentucky Medical Assistance Program, except in the case of an adverse action taken under Title XVIII (Medicare), binding upon the Medical Assistance Program. Adverse action taken against an individual provider under Medicare must be appealed through Medicare procedures.

SECTION IV - CONDITIONS OF PARTICIPATION

L. Annual Recertification

In accordance with Federal requirements, a hospice provider's certification and participation with the KMAP must run concurrently with the provider's license issued by the Kentucky Health Facilities and Health Services Certificate of Need and Licensure Board. Since hospice agencies are re-licensed annually, it will be necessary for hospice providers to be recertified with the KMAP on an annual basis.

If for any reason a hospice provider's license is not renewed, that provider's participation with the KMAP will be terminated and no payment will be made to the provider for services rendered after the expiration date of the previous year's license until such time as notification of relicensure is received by the KMAP.

Upon receipt of notification of relicensure, the provider will be recertified with the KMAP for the entire period of time covered by the new license.

SECTION V - ELIGIBILITY REQUIREMENTS

V. ELIGIBILITY REQUIREMENTS

In order to be eligible to elect hospice care as a Medicaid benefit, an individual must be entitled to Medicaid benefits and be certified as being terminally ill. "Terminally ill" is defined as having a medical prognosis that life expectancy is six months or less. Additionally, those medically indigent persons who are terminally ill and who would be Medicaid eligible if institutionalized may also qualify for hospice benefits.

A. Application for Medicaid Benefits

The medically-indigent individual who is not currently a Medicaid recipient, but who has been certified as being terminally ill and has requested the hospice service, may apply for Medical Assistance benefits at the local office of the Department for Social Insurance in the individual's county of residence. An interested party may apply on behalf of the individual.

A completed and signed copy of the Election of Medicaid Hospice Benefits form, MAP-374, will need to be presented to the local office at the time of application.

B. Duration of Benefits

Effective 1/01/89, there is no limit on the number of days a patient may receive hospice care.

C. Certification of Terminal Illness

The hospice must obtain the certification that an individual is terminally ill in accordance with the following requirements:

1. The hospice must obtain, no later than 2 calendar days after hospice care is initiated, written certification statements signed by the medical director of the hospice or the physician member of the hospice interdisciplinary group and the individual's attending physician if the individual has an attending physician.

2. The certification must include the statement that the individual's medical prognosis is that his or her life expectancy is six months or less and the signature(s) of the physician(s) required to certify the terminal illness. The hospice maintains the certification statements.

3. An individual who is eligible for Medicare hospice benefits must elect to use the Medicare benefits as the primary source of payment. The date Medicare eligibility begins must be entered on the Election of Medicaid Hospice Benefits Form (MAP-374). The KMAP may make co-payments for drugs and/or respite care.

4. For an individual who is eligible for both Medicare and Medicaid benefits and who resides in a long term care facility, room and board charges may be paid by Medicaid.

D. Election of Hospice Care

1. If an individual who meets eligibility requirements for hospice care elects to receive that care, an Election of Benefits Form (MAP-374) must be completed by the individual or the individual's representative who is, because of the individual's mental or physical incapacity, authorized in accordance with state law to execute or revoke an election for hospice care or terminate medical care on behalf of the terminally ill individual.

2. An election to receive Medicaid hospice care will be considered to continue indefinitely without a break in care, as long as the individual remains in the care of the hospice and does not revoke the election in writing. (Revocation of Medicaid Hospice Benefits Form, MAP-375)

3. The individual or representative may designate an effective date for the election that begins with the first day of hospice care or any other subsequent day of hospice care. The individual may not designate an effective date that is earlier than the date that the election is made.

4. An individual waives all rights to Medicaid benefits for the duration of the election of hospice care for the following services:

   a. Hospice care provided by a hospice other than the hospice designated by the individual (unless provided by arrangements made by the designated hospice).

   b. Any Medicaid services that are related to the treatment of the terminal condition for which hospice care was elected except for services provided by the individual's attending physician if that physician is not an employee of the designated hospice or receiving compensation from the hospice for those services.

5. The election statement includes the following:

   a. identification of the particular hospice that will provide care to the individual

   b. the individual's (or representative) acknowledgment that he or she has been given a full understanding of the palliative rather than curative nature of hospice care as it relates to his or her terminal illness

   c. acknowledgement that certain Medicaid services are waived by the election of hospice care

   d. the effective date of the election

   e. the signature of the individual or representative.

6. A copy of the election form for all clients who elect hospice coverage must be forwarded to the Department for Medicaid Services and to the local Department for Social Insurance Office.

SECTION V - ELIGIBILITY REQUIREMENTS

E. Revoking Election of Hospice Care

An individual (or representative) may revoke the election of hospice care at any time during the benefit period.

1. To revoke the election of hospice care, the individual (or representative) must complete the Revocation of Hospice Benefit, form MAP-375, and file with the hospice. A copy of this form must be submitted to the Department for Medicaid Services and to the local Department for Social Insurance Office.

2. Upon revocation of the election of Medicaid coverage of hospice care, the individual is no longer covered by Medicaid for hospice care, but if eligible, may resume Medicaid coverage under the regular scope of benefits. The individual may at any time elect to receive hospice coverage for any other benefit periods he or she is still eligible to receive.

F. Change of the Designated Hospice

An individual (or representative) may change the designation of the particular hospice from which the hospice care will be received once.

1. The change of the designated hospice is not a revocation.

2. To change the designated hospice provider, the individual (or representative) must complete form MAP-376, Change of Hospice Providers, and file with the hospice from which care has been received and with the newly designated hospice.

   A copy must also be forwarded to the Department for Medicaid Services and to the local Department for Social Insurance Office.

G. Inactive Status

A lapse in the hospice benefit is allowed if the patient's condition improves to an extent that active hospice services are temporarily unnecessary. If the patient's condition has improved, the patient may be placed in inactive status by the hospice agency until the patient's condition once again requires active hospice services.

No hospice services (including room and board or bed reservation days) may be billed for any patient in inactive status. The patient may revert to regular Medicaid benefits; however, since Medicaid eligibility for hospice patients is determined using a special income standard, some patients may not be eligible for Medicaid benefits during inactive status.

The Termination of Medicaid Hospice Benefits Form (MAP-378) or the Hospice Patient Status Change Form (MAP-403) must be used to notify the Department for Medicaid Services that the patient is entering inactive status.

When the patient returns to active status, a Hospice Patient Status Change Form (MAP-403) must be completed indicating the date that the patient will be in active status and must be sent to the Department of Medicaid Services and the local Department for Social Insurance Office and the patient will be again added to the hospice file.

H. Termination of Hospice Care

1. Notification of Death

The hospice agency is required to notify the Department for Medicaid Services of the death of a recipient no later than two (2) days following the death. Additionally a Termination of Medicaid Hospice Benefits Form (MAP-378) must be completed. A copy must be submitted to the Department for Medicaid Services and to the local Department for Social Insurance office.

2. Inactive Status

The hospice agency is required to notify the Department for Medicaid Services within two working days if the patient goes into inactive status using the Termination of Medicaid Benefits Form (MAP-378) or the Hospice Patient Status Change Form (MAP-403).

SECTION V - ELIGIBILITY REQUIREMENTS

H. Extension of Hospice Care Beyond Three Benefit Periods

At the end of the final 30-day benefit period, the KMAP will consider an extension of the hospice care benefits for up to sixty consecutive (60) days. The extension is to be requested by submission of the form, MAP-377, Request for Extension of Medicaid Hospice Benefits. This form requires a statement from the Hospice Medical Director that the patient's life expectancy is 60 days or less. Patients who have been in inactive status are also eligible for the 60 day extension and that period may be saved for as long as necessary.

The request for extension must be received by the Department for Medicaid Services, five days prior to the end of the 30 day benefit period.

I. Termination of Hospice Care

1. If hospice care is terminated because covered days have been exhausted, a Termination of Medicaid Hospice Benefits form (MAP-378) must be completed. A copy must be submitted to the Department for Medicaid Services and to the local Department for Social Insurance Office.

2. Notification of Death

The hospice agency is required to notify the Department for Medicaid Services of the death of a recipient no later than two (2) days following the death. Additionally a Termination of Medicaid Hospice Benefits Form (MAP-378) must be completed. A copy must be submitted to the Department for Medicaid Services and to the local Department for Social Insurance office.

3. Inactive Status

The hospice agency is required to notify the Department for Medicaid Services within two working days if the patient goes into inactive status using the Termination of Medicaid Benefits Form (MAP-378). The date the patient became inactive must be entered and the section marked "Other" must be completed indicating "inactive" status.

SECTION VI - COVERED SERVICES

VI. COVERED SERVICES

To be covered, hospice services must be reasonable and necessary for the palliation or management of the terminal illness as well as related conditions. The individual, having been certified as being terminally ill, must elect hospice coverage. A plan of care must be established and the services must be consistent with the plan of care.

A. General Coverage

The Medicare Guidelines have been followed in the development of the Medicaid Hospice Scope of Benefits. The following services are covered:

1. Core Services

A hospice must ensure that substantially all the core services are routinely provided directly by hospice employees. A hospice may use contracted staff, if necessary, to supplement hospice employees in order to meet the needs of patients during periods of peak patient loads or under extraordinary circumstances. If contracting is used, the hospice must maintain professional, financial and administrative responsibility for the services and must assure that the qualifications of staff and services provided meet all requirements.

2. Nursing Services

The hospice must provide nursing care and services by or under the supervision of a registered nurse.

a. Nursing services must be directed and staffed to assure that the nursing needs of patients are met.

b. Patient care responsibilities of nursing personnel must be specified.

c. Services must be provided in accordance with recognized standards of practice.

3. Counseling Services

Counseling services must be available to both the individual and the family. Counseling includes bereavement counseling provided after the patient's death, as well as dietary, spiritual, and any other counseling services for the individual and family provided while the individual is enrolled in the hospice.

a. There must be an organized program for the provision of bereavement services under the supervision of a qualified professional. The plan of care for these services should reflect family needs, as well as a clear delineation of services to be provided and the frequency of service delivery (up to one year following the death of the patient).

b. Dietary counseling, when required, must be provided by a qualified individual.

c. Spiritual counseling must include notice to patient as to the availability of clergy.

d. Counseling may be provided by other members of the interdisciplinary group as well as by other qualified professionals as determined by the hospice.

4. Physical Therapy, Occupational Therapy, and Speech-Language Pathology

Physical therapy, occupational therapy services and speech-language pathology services must be available and, when provided, offered in a manner consistent with accepted standards of practice.

5. Home Health Aide and Homemaker Services

Home Health aide and homemaker services must be available and adequate in frequency to meet the needs of the patients.

a. A registered nurse must visit the home site at least every two weeks when aide services are being provided, and the visit must include an assessment of the aide services.

b. Written instructions for patient care are prepared by a registered nurse. Duties include but may not be limited to the performance of simple procedures as an extension of therapy services, personal care, ambulation and exercise, household services essential to health care at home, assistance with medications that are ordinarily self-administered, reporting changes in the patient's condition and needs, and completing appropriate records.

6. Medical Supplies

Medical supplies and appliances, including drugs and biologicals must be provided as needed for the palliation and management of the terminal illness and related conditions.

a. All drugs and biologicals must be administered in accordance with accepted standards of practice.

b. The hospice must have a policy for the disposal of controlled drugs maintained in the patient's home when those drugs are no longer needed by the patient.

c. Drugs and biologicals are administered only by the following individuals.

(1) a licensed nurse or physician

(2) an employee who has completed a state-approved training program in medication administration

(3) the patient if his or her attending physician has approved

(4) any other individual in accordance with applicable state and local laws; the persons and each drug and biological they are authorized to administer must be specified in the patient's plan of care.

7. Short Term Inpatient Care

Inpatient care must be available for pain control, symptom management and respite purposes and must be provided in a participating Medicare or Medicaid facility.

a. Inpatient care for pain control and symptom management must be provided in a hospital or an SNF that also meets standards for direct inpatient care, and 24 hour nursing service.

b. Inpatient care for respite purposes must be provided by a hospital or an SNF that also meets the standards for direct inpatient care and 24 hour nursing service or an ICF that meets those same standards.

8. Medical Social Services

Medical social services must be provided by a qualified social worker, under the direction of a physician.

B. Special Coverage Requirements

When necessary, special coverage of some services will be available during period of crisis or for respite care.

1. Periods of Crisis

During periods of crisis, nursing care may be covered on a continuous basis for as much as 24 hours a day as necessary to maintain the individual at home. Either homemaker or home health aide services or both may be covered on a 24-hour continuous

basis during periods of crisis but care during these periods must be predominantly nursing care. A period of crisis is a period in which the individual requires continuous care to achieve palliation or management of acute medical symptoms.

2. Inpatient Respite Care

Respite Care is short-term inpatient care provided in a participating hospital, skilled nursing facility or intermediate care facility to the individual only when necessary to relieve the family members or other persons caring for the individual. Respite care may be provided only on an occasional basis and may not be reimbursed for more than five consecutive days.

3. Bereavement counseling is a required hospice service but is not directly reimbursable.

C. Physician Services

Physician services will not be covered as a separate service through the Hospice program but will continue to be payable through the physician element of the KMAP when billed by the physician in the usual manner.

D. Hospital Services

Inpatient hospitalization for illnesses or conditions not related to the patient's terminal illness will not be covered through the hospice program but will continue to be payable through the hospital element of the KMAP when billed by the hospital in the usual manner.

The Hospice should submit to the hospital an Other Hospitalization Statement (MAP-383) signed by the hospice medical director which says that it has been determined by the hospice that this illness/accident is not related to the terminal illness of the patient. A copy of the MAP-383 should be retained by the hospice agency.

E. Pharmacy

Drugs related to the terminal illness of the patient will be covered by the hospice program and included in the per diem rate.

For those drugs not related to the terminal illness of the patient, the hospice agency should complete a Hospice Drug Form (MAP-384) and submit both copies along with the Election of Benefits Form (MAP-374). The KMAP will return one copy to the hospice agency indicating the allowable maximum Medicaid payment for each drug. The hospice agency will bill the actual cost, up to the Medicaid maximums, for those drugs on the UB 82 billing form, using the revenue code 250 (General Classification). Payment will be made to the hospice for those drugs at 100% of the billed charge, up to the Medicaid maximum. The MAP-384 need be submitted only one time at the time of election of hospice coverage unless the prescriptions are changed or unless hospice coverage is revoked. If hospice coverage is revoked and then reinstated, a new MAP-384 should be submitted with the Election of Benefits form.

F. Room and Board

Room and board for hospice clients residing in a long term care facility which participates with Medicare will be covered by the hospice program and payment for room and board will be made in addition to the payment for routine hospice care and continuous care services. In this type of situation, the hospice agency is responsible for the professional management of the individual's hospice care and the long term care facility agrees to provide room and board. Medicaid payment will be made to the hospice agency and the hospice agency will make payment to the long term care facility.

In the case of continuous nursing care for clients residing in long term care facilities, all requirements for continuous nursing care in the home must be met; it will be the responsibility of the hospice agency to go into the long term care facility and provide continuous care for as long as necessary.

In order to assure appropriate eligibility determinations for clients residing in long term care facilities, the hospice must notify the local Department for Social Insurance whenever a client enters or leaves a long term care facility and indicate whether the facility is a skilled nursing facility or an intermediate care facility. If the patient is in a long term care facility at the time the hospice benefit is elected, the name of the facility and the type of facility (ICF or SNF) must be entered on the Election of Medicaid Benefits Form (MAP-374).

The reimbursement rate for room and board is set at 75% of the intermediate care upper limit for IC, and at 115% of the intermediate care add on for SN. When upper limits are revised for IC and SN, new room and board rates will be calculated accordingly.

Charges for room and board must be billed on the same UB-82 as the other procedures for those dates of services (i.e. routine home care or continuous nursing care) except for patients with both Medicare and Medicaid.

Charges for room and board may not be billed for patients who are in inactive status.

G. Bed Reservation Days

Bed Reservation Days for hospice clients residing in a long term care facility who require inpatient hospitalization will be covered by the hospice program in order to guarantee that the bed in the long term care facility will be available to the client upon discharge from the hospital. Payment for bed reservation days will be made to the hospice agency in addition to the payment for general inpatient care.

Reimbursement for bed reservation days will also be allowed for hospice clients residing in a long term care facility who temporarily return to a home setting for therapeutic purposes. In these instances, the hospice agency must continue to provide the patient's care and the payment for bed reservation days will be made in addition to the payment for either routine home care or continuous nursing care, whichever is appropriate.

In both instances Medicaid payment for bed reservation days will be made to the hospice agency and the hospice agency will make payment to the long term care facility.

The reimbursement rate for bed reservation days will be the same as the rate paid for room and board when the patient is actually in the long term care facility.

Payment for bed reservation days for the purpose of inpatient hospitalization will be limited to fourteen (14) consecutive days per recipient and a total of forty-five (45) days per lifetime.

Payment for bed reservation days for the purpose of therapeutic home visits will be limited to fifteen (15) days per lifetime.

If the patient dies while in the hospital or on a home visit, the long term care facility should be notified immediately. Payment for bed reservation days will not be made for any day after the date of death.

Charges for bed reservation days must be billed on the same UB-82 as the other procedures for those dates of service (i.e. general inpatient care, routine home care, continuous nursing care) except for patients with both Medicare and Medicaid. Charges for bed reservation days may not be billed for patients in inactive status.

H. Categories of Covered Services

Hospice services are divided into five basic categories of services plus two categories for room and board and, four categories for bed reservation days. With the exception of pharmacy items not related to the terminal illness, a payment rate is established by Medicare for each category. A revenue code is assigned to each category for billing purposes.

The categories of service and the revenue codes are as follows:

651 Routine Home Care - routine nursing service, social work, counseling services, durable medical equipment, supplies, drugs, home health aide/homemakers, physical therapy, occupational therapy and speech and language pathology therapy.

652 Continuous Home Care - in periods of acute medical crisis, 24 hour nursing care may be instituted in the home.

655 Respite Care - for a limited time, not to exceed five consecutive days, the patient may receive respite care in a licensed Skilled or Intermediate Care Facility, or acute care hospital.

656 General Inpatient - in periods of acute medical crisis, the patient may be hospitalized for palliative care.

653 Room and Board SNF - for hospice patients residing in a skilled nursing facility which participates with Medicare, room and board is paid in addition to the rate for routine home care and continuous home care. Charges must be billed in conjunction with the appropriate procedure code for services rendered on those dates (except for patients with both Medicare and Medicaid).

654 Room and Board ICF - for hospice patients residing in an intermediate care facility which participates with Medicare, room and board is paid in addition to the rate for routine home care and continuous home care. Charges must be billed in conjunction with the appropriate procedure code for services rendered on those dates (except for patients with both Medicare and Medicaid).

182 ICF Bed Reservation Days Home - for hospice patients residing in an intermediate care facility who return to a home setting temporarily for therapeutic purposes, bed reservation days (not to exceed 15 per lifetime) are paid in addition to the rate for routine home care or continuous nursing care. Charges must be billed in conjunction with the appropriate procedure code for services rendered on those dates.

183 SNF Bed Reservation Days Home - for hospice patients residing in a skilled nursing facility who return to a home setting temporarily for therapeutic purposes, bed reservation days (not to exceed 15 per lifetime) are paid in addition to the rate for routine home care or continuous nursing care. Charges must be billed in conjunction with the appropriate procedure code for services rendered on those dates.

184 ICF Bed Reservation Days Hospital - for hospice patients residing in an intermediate care facility who require inpatient hospitalization, bed reservation days (not to exceed 14 consecutive days or 45 total days per lifetime) are paid in addition to the rate for general inpatient care. Charges must be billed in conjunction with the appropriate procedure code for services rendered on those dates.

185 SNF Bed Reservation Days Hospital - for hospice patients residing in a skilled nursing facility who require inpatient hospitalization, bed reservation days (not to exceed 14 consecutive days or 45 total days per lifetime) are paid in addition to the rate for general inpatient care. Charges must be billed in conjunction with the appropriate procedure code for services rendered on those dates.

250 General Classification Pharmacy - prescriptions not related to the terminal illness.

I. Other Covered Services

Services which are not covered by the hospice program but which the patient may need are payable through other elements of the KMAP in accordance with the Medicaid scope of benefits. These services may include:

Medical Transportation
Dental
Renal Dialysis
Nurse Anesthetist

J. Services Not Related to the Terminal Illness

As with inpatient hospitalization for illnesses or conditions not related to the terminal illness of the patient, certain other services which are usually covered under the hospice benefit may be considered separately and billed to the KMAP by the appropriate provider if the service is determined to be totally unrelated to the terminal illness of the patient.

1. Durable Medical Equipment

   If a patient requires durable medical equipment for a condition that is separate from and totally unrelated to the terminal illness of the patient, charges for the equipment may be billed to the KMAP by a home health agency.

2. Outpatient Hospital Services

   If a patient requires outpatient hospital services for a condition that is separate from and totally unrelated to the terminal illness of the patient, charges for the services may be billed to the KMAP by the hospital. Prior approval must be obtained from the KMAP. The Other Hospitalization Statement (MAP-383) should be submitted to the KMAP for review along with documentation which includes the terminal diagnosis and present condition of the patient and verification that the reason for this hospitalization is in no way related to the terminal illness.

3. Other Services

   If a patient requires other medical services for a condition that is separate from and totally unrelated to the terminal illness of the patient, charges for the services may be billed to the KMAP by the appropriate provider.

   In all of the instances described above, prior approval must be obtained from the KMAP before payment can be made to providers other than the hospice agency. Prior approval may be obtained by submitting to the KMAP a completed Other Services Statement (MAP-397) along with documentation which clearly indicates that the services provided are in no way related to the terminal illness of the patient.

   A copy of the form will be returned to the hospice agency indicating whether or not the request has been approved.

   If approved, the hospice agency should forward the form to the provider who will be responsible for billing for the service. The hospice agency should retain a copy of the form.

SECTION VI - COVERED SERVICES

K. Nutritional Supplements

In most cases, nutritional supplements are considered part of the palliation and routine care of the hospice patient and charges for the nutritional supplements are included in the hospice agency's per diem rate. If, however, the condition of the patient is such that nutritional supplements provide the total nutrition of the patient, charges for the nutritional supplement may be billed separately and payment will be made in addition to the usual per diem rate; however, prior approval must be obtained from the KMAP. Payment will be made in accordance with the KMAP maximums allowed for nutritional supplements.

Prior approval may be obtained by submitting to the KMAP a completed Hospice Drug Form (MAP-384) along with documentation from the patient's physician which clearly indicates that the patient requires the nutritional supplement for his/her total nutrition.

If approved, the form will be returned to the hospice agency with the KMAP maximum for the nutritional supplement entered in block 12. That amount may then be billed to the KMAP on the UB-82, with or without other hospice charges, using code 250.

SECTION VII - REIMBURSEMENT

VII. REIMBURSEMENT

A. Method of Reimbursement

Hospice services are reimbursed on the basis of an established rate per unit for the covered service rendered. This rate is the same as the Medicare rate. Services must be provided in accordance with the terms and conditions described in this manual. The recipient receiving these services must be a Medicaid recipient and meet the eligibility criteria for hospice care.

B. Billing Form

The Universal Billing Form, UB-82, will be used to bill for Medicaid Hospice Services.

C. Covered Services/Revenue Codes

1. Routine Home Care

a. Revenue Code: 651
b. Unit of Service: 1 day (24 hours)

2. Continuous Home Care

a. Revenue Code: 652
b. Unit of Service: 1 hour (minimum 8 hours per 24 hour period)

3. Inpatient Respite Care

a. Revenue Code: 655
b. Unit of Service: 1 day (24 hours)

4. General Inpatient Care (Non-Respite)

a. Revenue Code: 656
b. Unit of Service: 1 day (24 hours)

5. Room and Board SNF

   a. Revenue Code: 653
   b. Unit of Service: 1 day (24 hours)

6. Room and Board ICF

   a. Revenue Code: 654
   b. Unit of Service: 1 day (24 hours)

7. ICF Bed Reservation Days Home

   a. Revenue Code: 182
   b. Unit of Service: 1 day (24 hours)

8. SNF Bed Reservation Days Home

   a. Revenue Code: 183
   b. Unit of Service: 1 day (24 hours)

9. ICF Bed Reservation Days Hospital

   a. Revenue Code: 184
   b. Unit of Service: 1 day (24 hours)

10. SNF Bed Reservation Days Hospital

    a. Revenue Code: 185
    b. Unit of Service: 1 day (24 hours)

11. General Classification Pharmacy (Prescriptions Not Related to Terminal Illness)

    a. Revenue Code: 250
    b. Unit of Service: 1 prescription = 1 unit

12. Total of All Billed Charges Revenue Code: 001

On any day on which the recipient is not an inpatient, the hospice is paid the routine home care rate unless the patient receives continuous care. The hospice payment on a continuous care day varies depending on the number of hours of continuous services provided. The continuous care rate is divided by 24 to yield an hourly rate. The number of hours of continuous care during a continuous home care day is then multiplied by the hourly rate to yield the continuous home care payment for that day. A minimum of eight hours of care must be provided on a particular day to qualify for the continuous home care rate.

On any day on which the recipient is an inpatient in an approved facility for inpatient care, the appropriate inpatient rate (general or respite) is paid depending on the category of care. The inpatient rate (general or respite) is paid for the date of admission and all subsequent inpatient days except the day on which the patient is discharged. For the day of discharge, the appropriate home care rate is paid.

Payment for inpatient respite care may not be for more than 5 consecutive days; payment for the sixth and any subsequent days of inpatient respite care is made at the routine home rate.

If the recipient dies while an inpatient, and is discharged deceased, the inpatient rate (general or respite) is paid for the discharge day.

For recipients residing in a skilled nursing or intermediate care facility payment for room and board for each day is made in addition to the payment for routine home or continuous home care for that day. (In the case of continuous care, the hospice agency must go into the long term care facility and provide continuous nursing care services.)

For recipients residing in a skilled nursing or intermediate care facility and who are out of the facility due to inpatient hospitalization or home visitation, payment for bed reservation days for each day the patient is out of the facility will be made in addition to the payment for routine home care, continuous nursing care or general inpatient care, whichever is applicable. (In the

case where the patient is away from the long term care facility for home visitation, the hospice agency must continue to provide the patient's care.) Payment for bed reservation days will be limited to a maximum of 14 consecutive days and a total of 45 days per lifetime per recipient for inpatient hospitalization and a maximum of 15 days per lifetime per recipient for home visitation. Payment for any days in excess of these limitations will be disallowed.

Payment by the KMAP will constitute reimbursement in full and will relieve the Program and the recipient of further liability.

All providers must make fair and equal charges for every person served and in no case may charges for Program recipients or payment on their behalf exceed charges to other patients for the same or similar service.

D. Reimbursement in Relation to Medicare

Recipients who are eligible for both Medicare and Medicaid and who are receiving hospice benefits through the Medicare program may elect to have the five percent co-payment for drugs and respite care reimbursed by the KMAP.

The co-payment reimbursement will be a maximum of 5% per prescription cost of the drug and/or biological and 5% of the payment made by HCFA for a respite care day but may not exceed $5.00 per day for respite or $5.00 per prescription.

A copy of the Medicare EOMB must be attached to the UB-82 as well as the invoice for the drugs and/or biologicals to which the five percent co-payment is applied. (Please refer to Section VIII C for billing instructions.)

All forms and enrollment procedures (see Section V for eligibility requirements and Section VIII for completion of forms) which apply to clients who have Medicaid only also apply to clients with both Medicare and Medicaid.

Recipients identified as Qualified Medicare Beneficiaries (QMB) only are eligible only for co-payment for drugs and respite care.

E. Other Third Party Coverage

The 1967 amendments to the Social Security Law stipulate that Title XIX programs have secondary liability for medical costs of Program recipients. That is, if the patient has an insurance policy, veteran's coverage, or other third party coverage of the expenses of the services rendered, that party is primarily liable for the patient's expenses. The KMAP has secondary liability. Accordingly, the provider of service should first seek reimbursement from such third party group. If you as the provider should receive payment from the KMAP before knowing of the third party's liability, a refund of the payment amount should be made to the "Kentucky State Treasurer" and mailed to EDS, P.O. Box 2009, Frankfort, Kentucky 40602, Attention: Cash/Finance Unit. The amount payable by the Cabinet shall be reduced by the amount of the third party obligations.

1. Identification of Third Party Resources

Pursuant to KRS 205.662, prior to billing the Kentucky Medical Assistance Program all participating vendors shall submit billings for medical services to a third party when such vendor has prior knowledge that such third party may be liable for payment of the services.

In order to identify those recipients who may be covered through a variety of health insurance resources, the provider should inquire if the recipient meets any of the following conditions:

-If the recipient is married or working, inquire about possible health insurance through the recipient's or spouse's employer;
-If the recipient is a minor, ask about insurance the mother, father, or guardian may carry on the recipient;

-In cases of active or retired military personnel, request information about CHAMPUS coverage and social security number of the policy holder;
-For people over 65 or disabled, seek a Medicare HIC number;
-Ask if the recipient has health insurance such as a Medicare Supplement policy, cancer, accident, or indemnity policy, group health or individual insurance, etc.

Examine the recipient's MAID card for an insurance code. If a code indicates insurance coverage, question the recipient further regarding the insurance.

2. Billing Instructions for Claims Involving Third Party Resources

If the patient has third party resources, then the provider must obtain payment or rejection from the third party before Medicaid can be filed. When payment is received, the provider should indicate on the claim form in the appropriate field the amount of the third party payment and the name and policy numbers of health insurance covering the recipient. If the third party rejected the claim, a copy of the rejection notice must be attached to the Medicaid claim.

Exceptions:

*If the other insurance company has not made payment within 120 days of date of filing a claim to the insurance company, submit with the Medicaid claim a copy of the other insurance claim to EDS indicating "NO RESPONSE" on the Medicaid claim form. Then forward a completed TPL Lead form to:

EDS
P.O. Box 2009
Frankfort, KY 40602
Attn: TPL Unit

*If proof of denial for the same recipient for the same or related services from the carrier is attached to the Medicaid billing, claims processing can proceed. The denial cannot be more than six months old.

*A letter from the provider indicating that he/she contacted XYZ insurance company and spoke with an agent to verify that the recipient was not covered, can also be attached to the Medicaid claim.

3. Medicaid Payment for Claims Involving a Third Party

Claims meeting the requirements for KMAP payment will be paid in the following manner if a third party payment is identified on the claim.

The amount paid by the third party will be deducted from the Medicaid allowed amount and the difference paid to the provider. If the third party payment amount exceeds the Medicaid allowed amount, the resulting KMAP payment will be zero. Recipients cannot be billed for any difference between the billed amount and Medicaid payment amount. Providers must accept Medicaid payment as payment in full.

Claims for services involving a private insurace company that has made a payment to the recipient can only be paid the difference between the allowable Medicaid rate and the insurance amount paid. The amount paid is to be entered in the appropriate block to enable the claim to pay.

The TPL Lead Form is used in cases where no response has been received from the insurance company and 120 days have elapsed since the submission of the claim. In that case, the claim will be paid at the Medicaid allowable rate and EDS will then pursue collection from the company. An example of the TPL Lead Form may be found in the Appendix Section of this manual, Appendix XV.

If the claims for a recipient are payable by a third party resource which was not pursued by the provider, the claim will be denied. Along with a Third Party insurance denial explanation, the name and address of the insurance company, the name of the policy holder, and the policy number will be indicated. The provider must pursue payment with this third party resource before billing Medicaid again.

If you have any questions, please write to EDS, P.O. Box 2009, Frankfort, Kentucky 40602, Attention: Third Party Unit, or call (800) 333-2188.

F. Client's Continuing Income Liability

If it is determined by the local office of the Department for Social Insurance that a client has income in excess of the monthly eligibility standard, the amount of excess income is to be paid to the provider by the recipient or responsible party and shall be deducted from the Title XIX payments. Notification of the amount of excess income shall be forwarded to the Hospice provider from the Department for Medicaid Services on Form MAP-552. (See Appendix XVI) It is the responsibility of the provider to collect this money from the client.

Providers should continue to bill all covered Hospice services received by the client to the KMAP.

The applicable continuing income will be pro-rated and deducted from Medicaid payments on a per diem basis.

G. Spend Down

Spend down is defined as the utilization of excess income for recognized medical expenses. If a client has income greater than that which is usually permitted for Medicaid eligibility, the local office of the Department for Social Insurance, using a standard computation formula, determines the excess income for a three month period. This quarterly excess is the spend-down amount which must be applied toward incurred or paid medical expenses. The medical card becomes effective on the date on which the quarterly excess income amount is met. Spend down eligibility may be determined for a period three months prior to the application or for a three month period after the application. An MA spend-down eligibility card is a time limited card and requires re-application quarterly.

H. Special Income Provisions

Special income provisions are allowed for Medicaid eligibility for all Hospice clients who are either married or under age eighteen (18). The income and resources of the spouse or parents will be considered available to the Hospice client for the month of admission only.

For the second month and each succeeding month of Hospice participation, only the income and resources of the Hospice client will be used to determine Medicaid eligibility. Additionally, all Hospice clients will be allowed to retain from their own income for their basic maintenance needs an amount equal to the SSI basic benefit rate plus the SSI general disregard.

I. Duplicate or Inappropriate Payments

Any duplicate or inappropriate payment by the KMAP, whether due to erroneous billing or payment system faults, must be refunded to the KMAP. Refund checks should be made payable to "Kentucky State Treasurer" and sent immediately to:

EDS
P.O. Box 2009
Frankfort, KY 40602

ATTN: Cash/Finance Unit

Failure to refund a duplicate or inappropriate payment could be interpreted as fraud or abuse, and prosecuted as such.